Agency Code: _ _ _ _ _ _
Check Dist. Code _ _ _ _ _ _

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT FORM FOR JULY 2008-JUNE 2009

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name:
Address:
City **State** **Zip Code**

Home Phone: ( ) __ __ __- __ __ __ __
Work Phone: ( ) __ __ __ - __ __ __ __
Cell Phone: ( ) __ __ __ - __ __ __ __

Pay Center:
Pay Cycle:

Social Security Number: __ __ __ /__ __ / __ __ __ __

Date of Birth: ____/____/_____

PLEASE COMPLETE: (MARK ALL APPROPRIATE CIRCLES)

I work full-time or 50% or more of the normal week:

I work_____hrs. per week

Pay Center
○ Central Payroll
○ University of MD
○ Satellite (specify agency: _____)

I am paid:
○ Biweekly
○ Monthly

I am 21-Pay Faculty
○ Yes
○ No

Sex:
○ Male
○ Female

Marital Status:
○ Single
○ Married
○ Divorced
○ Limited Divorce/ Legally Separated
○ Widowed

EMPLOYEE STATUS

○ New Employee. Entry on duty date: _____
○ Return from leave of absence/LAW Date: _____
○ Transfer from: _____ (Agency Code) to _____ (Agency Code)
○ Employee requesting change due to change in family status
○ Employee ineligible (e.g., change to part-time less than 50%)

Note on Retroactive Adjustments:
Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn Retroactive Adjustments are required to be backdated to date of birth.

ENROLLMENT/CHANGE ACTION REQUESTED

○ New Enrollment (New employee/return from LAW):
○ Change in family status
  ○ Add spouse or dependent because of:
    ○ Marriage Date: _____
    ○ Birth/Adoption/Appointed Permanent Legal Guardian Date: _____
    ○ Other: _____
  ○ Remove spouse or dependent because of:
    ○ Divorce/Limited Divorce/Legal Separation Date: _____
    ○ Death Date: _____ *(Attach copy of Death Certificate)*
    ○ Dependent no longer eligible-explain: _____
○ Other Change: _____
  ○ Cancel all coverage-explain: _____
  _____

DEPENDENT INFORMATION *PLEASE PRINT - DEPENDENTS INCLUDE YOUR SPOUSE AND CHILDREN*

YOU MAY USE THIS SECTION FOR ADDITIONS (A), CHANGES (C) OR DELETIONS (D) TO YOUR EXISTING HEALTH BENEFITS FILE. COMPLETE ALL INFORMATION FOR EACH ENTRY. PLEASE PRINT CLEARLY.

A/C/D	*LAST NAME*	*FIRST NAME*	*MI*	*SEX*	*BIRTH DATE*	*RELATIONSHIP*	*SOCIAL SECURITY NO.*	*COVER THIS DEPENDENT FOR: HEALTH*	*DRUG*	*DENTAL*

NOTE: If you are adding or removing a dependent, please see your Benefits Book for dependent documentation requirements. Tax-qualified dependent children age 25 and over must be disabled prior to reaching age 25.

ENROLLMENT FOR JULY 2008-JUNE 2009

Medical Benefits

OPTIONS
- ○ New Enrollment or Change in Enrollment
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more
- ○ End Stage Renal (ESRD) (Complete Medicare Information below)

MEDICAL PLANS-Choose only one

PPO Plans:
- ○ BC/BS PPO
- ○ MLH Eagle PPO

POS Plans:
- ○ Aetna POS
- ○ BC/BS MD POS
- ○ MD IPA Preferred POS

HMO Plans:
- ○ BlueChoice HMO
- ○ Kaiser HMO
- ○ Optimum Choice HMO

NOTE: Medicare Part D is voluntary. See the Notice of Creditable Coverage letter for the State's prescription drug plan in the Benefits Book.

NAMES OF INDIVIDUALS WITH MEDICARE	*MEDICARE NUMBER*	*PART A (Hospital Claims) Effective Date*	*PART B (Medical Claims) Effective Date*	*PART D (Prescription Drug) Effective Date*	*MEDICARE DUE TO (✓):* *Age 65*	*Disabled*	*ESRD*
Employee							
Spouse							
Dependent Child							
Dependent Child							

NOTE: Vision and Mental Health/Substance Abuse benefits <u>are available</u> if enrolled in a medical plan. Medical plans <u>do not include</u> Prescription Drug or Dental coverage. See the following sections.

Prescription Coverage

OPTIONS
- ○ New enrollment
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more

Dental Coverage

OPTIONS
- ○ New enrollment or change in plan
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more

DENTAL PLANS

Check only one dental plan:
- ○ Dental Benefits Providers Dental HMO
- ○ United Concordia Dental HMO
- ○ United Concordia Dental PPO

Personal Accident and Dismemberment

OPTIONS
- ○ New Enrollment or addition/removal of dependent
- ○ Change of benefit amount - select benefit amount
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Employee only coverage
- ○ Family coverage

BENEFIT AMOUNT
- ○ $100,000
- ○ $200,000
- ○ $300,000

Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

<u>YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT IN JULY 2008-JUNE 2009</u>

HEALTH CARE

OPTIONS
- ○ **Enroll** in Health Care Spending Account
- ○ **Cancel** Health Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount **per deduction***

DAY CARE

OPTIONS
- ○ **Enroll** in Day Care Spending Account
- ○ **Cancel** Day Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount **per deduction***

If you will be retiring before July 1, 2009, please be advised that only expenses incurred prior to retirement can be considered for reimbursement. Only expenses for tax-qualified dependents may be reimbursed.

See Benefits Book for Minimum/Maximum deduction amounts. Check with your Benefits Coordinator for your number of deductions, i.e., 24, 21 or 19.
Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT PER DEDUCTION IN JULY 2008-JUNE 2009.

State Life Insurance Plan

EMPLOYEE

OPTIONS

- ○ Yes, I want to enroll as a new enrollee in life insurance. Select benefit amount.
- ○ I am currently enrolled in life insurance and making a change. Select benefit amount.
- ○ No, I do not want to start life insurance for myself.
- ○ Cancel employee life insurance.

Choose a Coverage Amount in increments of $10,000 for yourself:

STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

$ ☐☐☐,■■■

SPOUSE

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your spouse can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance for myself, I wish to have life insurance on my spouse. Select benefit amount.
- ○ I currently have life insurance for my spouse and am making a change. Select benefit amount.
- ○ No, I do not want to start life insurance on my spouse.
- ○ Cancel spouse life insurance on my spouse.

Choose a Coverage Amount in increments of $5,000 for your spouse- up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for your spouse. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for your spouse.

Fill in the amount of Benefit

$ ☐☐☐,■■■

CHILDREN

SECTION 3: CHILDREN INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your children can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance on my myself, I wish to have life insurance for my child(ren). Select benefit amount.
- ○ I currently have life insurance for my child(ren) and am making a change. Select benefit amount.
- ○ No, I do not want to start life insurance on my child(ren).
- ○ Cancel child life insurance on my child(ren).

Choose a Coverage Amount in increments of $5,000 for your child(ren)- up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for each covered child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered child.

Fill in the amount of Benefit

$ ☐☐☐,■■■

Employee Signature

Please enroll me for the Flexible Benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by Section 125 of the Internal Revenue Code.**

I understand that if I have enrolled in one or both of the Flexible Spending Accounts, that I must file for reimbursement from those accounts by October 15, 2009 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through June 30, 2009 and can only be modified if there is a qualifying change in family status.

I understand that the Flexible Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for July 2008-June 2009. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2009. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.**

I CERTIFY THAT I AND ANY DEPENDENTS LISTED FOR COVERAGE ARE ELIGIBLE FOR COVERAGE. I UNDERSTAND THAT ENROLLMENT IN BENEFITS TO WHICH I OR MY DEPENDENTS ARE NOT ENTITLED IS CONSIDERED FRAUD. **IN ALL CASES I AM RESPONSIBLE FOR THE ACCURACY OF MY BENEFITS, COVERAGE LEVELS AND DEDUCTIONS.** I FURTHER UNDERSTAND THAT IF I WILLFULLY MISREPRESENT THE ELIGIBILITY OF MYSELF OR MY DEPENDENTS ON MY HEALTH BENEFITS APPLICATION, OR FAIL TO TAKE THE NECESSARY ACTION TO REMOVE INELIGIBLE DEPENDENTS, OR IN ANY WAY OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED, MY BENEFITS WILL BE CANCELED. I MAY BE REQUIRED TO REPAY ANY CLAIMS AND INSURANCE PREMIUMS WHICH HAVE BEEN PAID INAPPROPRIATELY, I MAY FACE CHARGES FOR DISMISSAL FROM STATE SERVICE, AND I MAY FACE CRIMINAL INVESTIGATION AND PROSECUTION.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Is there any other health insurance coverage in which you, your spouse or any of your dependents are enrolled? ○ Yes ○ No

Specify who is covered, name of Insurance Company and Policy Number:_____

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ _____/_____/_____ (_____) _____ (_____) _____

Employee Signature | Date | Work Phone Number (Ext.) | Your Home/Cell Phone Number

Agency Signature - *Agency Must Sign Here* FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

X _____ _____/_____/_____ (_____) _____ _____

Agency Benefits Coordinator | Date | Work Phone Number (Ext.) | Department

During the July 1, 2008 - June 30, 2009 Plan Year:

Completed and signed enrollment forms must be given to your Agency Benefits Coordinator. If you are covering dependents, all appropriate dependent documentation must be attached. Please see your Benefits Book for dependent documentation.

Health Benefits information and forms are available on the Department of Budget and Management's website:
www.dbm.maryland.gov.
Select ***State Employees*** and ***Health Benefits.***